Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Public Report

Report Issue Date: July 2, 2025
Inspection Number: 2025-1505-0007
Inspection Type: Critical Incident
Licensee: Shalom Manor Long Term Care Home
Long Term Care Home and City: Shalom Manor Long Term Care Home, Grimsby

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: June 25, 26, 30, 2025 and July 2, 2025.

The following intakes were inspected:

- Intake #00146167 [Critical Incident #3009-000006-25] - Falls Prevention and Management.

The following **Inspection Protocols** were used during this inspection:

Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (8)
Plan of care
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee failed to ensure that the staff and others who provided direct care to a resident had convenient and immediate access to their plan of care.

A resident required a specific type of wheelchair. This was captured in their written care plan and Kardex, the latter of which direct care staff indicated is how they access the resident's plan of care. Later, the resident required a different wheelchair, however, their written care plan and thus Kardex were not adjusted to reflect this change. The discrepancy was remedied on June 30, 2025.

Sources: Observations of resident, resident's written care plan and Kardex, and interview with staff.

Date Remedy Implemented: June 30, 2025

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure that the care set out in the plan of care for a resident was provided to the resident as specified in their plan.

A resident's written care plan and Kardex indicated the need for a fall prevention device. On three separate occasions during the course of this inspection, the device was not in place.

Sources: Observations of resident, resident's written care plan and Kardex, and interviews with staff.

WRITTEN NOTIFICATION: Required programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (2) (b)
Required programs
s. 53 (2) Each program must, in addition to meeting the requirements set out in section 34,
(b) provide for assessment and reassessment instruments. O. Reg. 246/22, s. 53 (2).

The licensee failed to ensure that the Falls Prevention Program provided for assessment and reassessment instruments.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that the Falls Prevention Program provided for assessment and re-assessment instruments. Specifically, staff did not comply with the home's policy that states the Glasgow Coma Scale must be initiated when a resident sustains a head injury, and that the Neurological Assessment Record (Appendix A) is to be repeated every 30 minutes for the first hour.

On a specified date, a resident fell and injured their head. The Glasgow Coma Scale was initiated, however, it was not repeated within the first hour post-fall.

Sources: Shalom Manor Falls Prevention Program Policy (January 15, 2025),

resident's progress notes, assessments and interviews with staff.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident (subject to subsection (4)): an incident that caused an injury to a resident for which they were taken to hospital and that resulted in a significant change in their health condition.

Sources: Resident's care plan, Critical Incident Report, and interview with staff.

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